

Exhibit A-Definition of Services

CONTRACTOR:

CONTRACTOR ID#:

CONTRACT PERIOD: Date of Contract

SERVICE DESCRIPTION: Crisis Respite Services (See Below)

RATE:

NOT TO EXCEED AMOUNT:

PAYMENT DOCUMENTATION: Billing due by 2nd business day after the month in which services were rendered. The remaining pages describe in detail the type, frequency, quantity, and durations of services with defined goals, outputs, and measurable outcomes which directly relate to program objectives and consumer needs.

From the Department of State Health Services
<http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>

Item V:

V. Crisis Residential Services

A. Definition

Crisis residential services provide short-term, community-based residential, crisis treatment to persons who may pose some risk of harm to self or others and who may have fairly severe functional impairment. Crisis residential facilities provide a safe environment with staff on site at all times. However these facilities are designed to allow individuals who are receiving services in these facilities to come and go at will. Individuals served in these facilities must have at least a minimal level of engagement to be served in this environment. Utilization of these services is managed by the Local Mental Health Authority (LMHA) based on medical necessity. The recommended length of stay ranges from 1-14 days. Crisis residential facilities are distinct from Crisis Stabilization Units (CSUs) in that crisis residential facilities provide a less restrictive and less intensive level of care than CSUs and crisis residential facilities do not accept individuals who are court committed for treatment.

B. Goals

- Conduct or ensure that a comprehensive assessment has been conducted.
- Stabilize the immediate crisis
- Restore sufficient functioning to allow the individual to transfer to a less intensive level of care
- Provide the individual with critical coping skills to prevent or minimize relapse
- Mobilize individual/family/community resources and support systems
- Link the individual with continuing care and appropriate support services
- Prevent unnecessary hospitalization and assist the individual in maintaining residence in the community

C. Description

Crisis residential treatment involves 24-hour residential services that are short-term. Crisis residential treatment is offered to individuals who are demonstrating psychiatric crises that cannot be stabilized in a less intensive setting. This level of care provides a safe environment to individuals with trained and competent staff on site at all times. However, there is only moderate/limited monitoring and reassessment of individuals to ensure safety. Crisis residential services may attempt to re-create a normalized environment (e.g., apartments, group and foster homes, and the individual's own home). This normalized environment provides a venue for biological, psychological, and social interventions targeted at the current crisis while fostering community reintegration. A physician, (preferably a psychiatrist), or a psychiatric APN or PA and RN must be on site or readily accessible to provide face-to-face services either in person or via telemedicine (as appropriate).

Psychosocial programming shall be provided as medically necessary and should focus on a range of topics that includes but is not limited to: problem-solving, communication skills, anger management, community re-integration skills, as well as co-occurring psychiatric and substance use diagnosis issues. Individual counseling shall also be provided as necessary. Individuals should have enough medication on arrival to ensure psychiatric and medical stabilization for at least 3 days and a process must exist to obtain medical and psychiatric medications as needed by the individual. The availability of crisis residential services is dependent on LMHA funding for these types of services. The recommended maximum length of stay is 14 days and the average anticipated length of stay is between 3 and 7 days.

D. Standards

1. Availability

- a. If provided, this service shall be available 24 hours a day, seven days a week to individuals in crisis in the local service area.
- b. Admission to crisis residential shall be determined by the LMHA and based on medical necessity as determined by a Licensed Practitioner of the Healing Arts (LPHA).
- c. When appropriate, the LPHA may use telemedicine to make the determination of need for admission.

2. Physical Plant

- a. If the LMHA holds an Assisted Living Type A license, the facility will be accepted as "deemed status" by DSHS, and any Quality Management and Compliance reviews will entail only programmatic elements.
- b. Crisis residential service units shall provide a clean and safe environment.
- c. Crisis residential services shall create as normalized an environment as possible.
- d. Crisis residential services units shall not be designed to prevent elopement and shall not use locks, mechanical restraints or other mechanical mechanisms to prevent elopement from the facility.
- e. All medications shall be securely stored.

3. General Facility Environment

- a. Waste water and sewage shall be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
- b. The water supply shall be of safe, sanitary quality, suitable for use and adequate in quantity and pressure, and must be obtained from a water supply system
- c. Waste, trash and garbage shall be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations shall not be permitted. The facility shall comply with 25 TAC Subsection 1.131-1.137 (concerning Definition, Treatment, and Disposal of Special Waste from Health Care Related Facilities).
- d. Operable windows shall be insect screened.
- e. An ongoing pest control program shall be provided by facility staff or by contract with a licensed pest control company. The least toxic and least flammable effective chemicals shall be used.
- f. In kitchens and laundries, facility staff shall use procedures to avoid cross-contamination between clean and soiled utensils and linens.
- g. The facility shall be kept free of accumulations of dirt, rubbish, dust and hazards.
- h. Floors shall be maintained in good condition and cleaned regularly.
- i. Walls and ceilings shall be structurally maintained, repaired and repainted or cleaned as needed.
- j. Storage areas and cellars shall be kept in an organized manner.
- k. Storage shall not be permitted in the attic spaces.
- l. The building shall be kept in good repair, and electrical, heating and cooling systems shall be maintained in a safe manner.
- m. There shall be at least one telephone in the facility available to both staff and consumers for use in case of an emergency.
- n. Cooling and heating shall be provided for occupant comfort. Conditioning systems shall be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in consumer-use areas.
- o. A bedroom shall have no more than four beds.
- p. The facility shall provide for each consumer a bed with mattress, bedding, chair, dresser (or other drawer space), and enclosed closet or other comparable space for clothing and personal belongings
- q. Furnishings provided by the facility shall be maintained in good repair.
- r. At least one water closet, lavatory, and bathing unit shall be provided on each sleeping floor accessible to consumers of that floor.
- s. One water closet and one lavatory for each six occupants or fraction thereof shall be provided. One tub or shower for each ten occupants or fraction thereof shall be provided.
- t. Privacy partitions and or curtains shall be provided at water closets and bathing units in rooms for multi-consumer use.
- u. Tubs and showers shall have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
- v. Consumer-use hot water for lavatories and bathing units shall be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
- w. Towels, soap and toilet tissue shall be available at all times for individual consumer use.
- x. The facility shall provide sufficient and appropriate separate storage spaces or areas for the following:
 - 1) Administration and clinical records;
 - 2) Office supplies;
 - 3) Medications and medical supplies (these areas shall be locked);
 - 4) Poisons and other hazardous materials (these shall be kept in a locked area and must be kept separate from all food and medications);
 - 5) Food preparation (if the facility prepares food); and
 - 6) Equipment supplied by the facility for consumer needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment etc.
- y. A supply of hot and cold water shall be provided. Hot water for sanitizing shall reach 180 degrees F. or manufacturers suggested temperature for chemical sanitizers.
- z. Food storage areas shall provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.
- aa. Food subject to spoilage shall be dated.
- ab. A large facility (i.e., a facility with more than 16 beds) which co-mingles and processes laundry on-site in a central location shall comply with the following:
 - 1) The laundry shall be separated and provided with sprinkler protection if located in the main building. (Separation shall consist of a one-hour fire rated partition carried to the underside of the floor or roof deck above.)
 - 2) Access doors to the laundry area shall be from the exterior of the facility or if from within the building by, way of non-consumer use areas.
 - 3) Soiled linen receiving, holding and sorting rooms shall have a floor drain and forced exhaust to the exterior shall operate at all times that soiled linen being held in this area.
- ac. If laundry is processed off the site, the following shall be provided on the premises: soiled linen holding room, clean linen receiving, holding, inspecting, sorting or folding and storage room.
- ad. Consumer-use laundry, if provided, shall utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area shall be one-hour fire separated or provided with sprinkler protection.
- ae. Smoking regulations shall be established and if smoking is permitted, outdoor smoking areas may be designated for consumers. Ashtrays of noncombustible material and safe design shall be provided in smoking areas.
- af. Social-divisional spaces such as living rooms, day rooms, lounges, or sunrooms shall be provided and have appropriate furniture.
- ag. Dining areas shall be provided and have appropriate furnishings.
- ah. Only break-away or collapsible clothes bars in wardrobes, lockers, towel bars, and closets and shower curtain rods shall be permitted.
- ai. Bedrooms, private spaces, unsupervised social spaces and unsupervised common areas shall not contain any cords, ropes or other materials that could effectively be used by an individual for purposes of inflicting self harm.

4. Accessibility (ADA Compliance)

Crisis residential facilities shall comply with ADAAG / TAS, and all applicable sections of the Texas Administrative Code.

5. Postings

- a. The facility shall ensure that there is a list in or near or within the medication room stating the names of all staff that can have access to the medication room.
- b. Emergency telephone numbers, including at least fire, police, ambulance, EMS, and poison control center, shall be posted conspicuously at or near the telephone.
- c. If smoking areas are permitted, the facility shall ensure that they are clearly marked as designated smoking areas.

- d. The facility shall post a notice that prohibits firearms and other weapons, alcohol, illegal drugs, illegal activities, and violence on the program site.
 - e. The facility shall post an emergency evacuation floor plan.
 - f. The following shall be prominently displayed in areas frequented by the consumers:
 - 1) Contact information for the Rights Protection Officer;
 - 2) Contact information with instructions on how to make an abuse/neglect report, toll-free number for reporting abuse and neglect; and
 - 3) A notice stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
 - g. Postings shall be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.
 - h. If the facility prepares food, the facility shall post the current food service permit from the local health department.
- 6. Safety**
- a. The facility shall comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code (IFC). Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.
 - b. All facilities shall be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code.
 - c. Facilities shall maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
 - d. The facility shall conduct fire drills and, when applicable, calculate evacuation scores in accordance with the fire code under which the facility is inspected.
 - e. Facilities shall provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections shall be signed and dated.
 - f. Initial and ongoing inspections for compliance with the applicable code shall be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State fire marshal. The facility is responsible for arranging these inspections and for ensuring that these inspections are carried out in a timely manner. The initial and ongoing fire safety reports shall be signed by the certified inspector performing inspection. These reports shall be kept on file and be readily available for review by the state.
 - g. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff shall take immediate corrective action to bring the facility into compliance with the applicable code. The facility shall have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions. After that date, the facility must have on file documentation by the Certified Fire Inspector that all shall have been corrected and that the facility is in full compliance with all applicable codes. During the period of corrective action, the facility shall take any steps necessary to ensure the health and safety of individuals residing in the facility during the time the repairs or corrections are being completed.
 - h. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in the State of Texas. Such certification shall be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as a crisis residential or crisis respite facility. If the facility has been remodeled or renovated the inspection by the architect shall have been conducted after the remodeling or renovation was completed.
 - i. The following initial and annual inspections are required and shall be kept on file:
 - 1) Local Fire safety as outlined in 6.f., above;
 - 2) Alarm system by the fire marshal or an inspector authorized to install and inspect alarm systems;
 - 3) Annual kitchen inspection by the local health authority or the Department of State Health Services;
 - 4) Gas pipe pressure test once every three years by the local gas company or a licensed plumber;
 - 5) Inspection and maintenance of fire extinguishers by personnel licensed or certified to perform the inspection; and
 - 6) (If applicable) inspection of liquefied petroleum gas systems by an inspector certified by the Texas Railroad Commission.
 - j. All fires causing damage to the crisis residential service unit or to equipment shall be reported to the DSHS Contract Manager with 72 hours. Any fire causing injury or death shall be reported to the DSHS Contract Manager immediately. Notification shall be by telephone if during normal business hours and by e-mail during other times with a follow-up telephone call to the Contract Manager on the first business day following the event.
 - k. All facilities shall post emergency evacuation floor plans.
 - l. The administration shall have in effect and available to all supervisory personnel written copies of a plan for the protection of all persons in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary. The plan shall include special staff actions including fire protection procedures needed to ensure the safety of any resident and must be amended or revised when needed. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. A copy of the plan shall be readily available at all times within the facility. This written plan shall require documentation that reflects the current evacuation capabilities of the consumers.
 - m. Open flame heating devices shall be prohibited. All fuel burning heating devices shall be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.
 - n. All vehicles used to transport consumers shall be maintained in safe driving condition.
 - o. Every vehicle used for consumer transportation shall have a fully stocked first aid kit and an A:B:C type fire extinguisher that are easily accessible.
 - p. Any vehicle used to transport a consumer shall have appropriate insurance coverage..
 - q. The facility shall ensure that consumer bedrooms, bath rooms and other private or unsupervised areas are free of materials that could be utilized by a consumer to cause harm to self or others. Such items include but are not limited to, ropes, cords (including window blind cords), sharp objects, and substances that could be harmful if ingested.
 - r. The facility shall not admit individuals whose needs cannot be effectively addressed in the facility. Individuals requiring a greater or lesser level of care shall be referred to a more appropriate level of care.
- 7. Infection Control**
- a. Each facility shall establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
 - b. The facility shall comply with departmental rules regarding special waste in 25 TAC §§1.131-1.137.
 - c. The facility shall have written policies for the control of communicable disease in employees and consumers, which includes tuberculosis screening and provision of a safe and sanitary environment for consumers and employees. The name

of any consumer of a facility with a reportable disease as specified in 25 TAC §§97.1-97.13 (Control of Communicable Diseases) shall be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.

- d. If employees contract a communicable disease that is transmissible to consumers through food handling or direct consumer care, the employee shall be excluded from providing these services as long as a period of communicability is present.
 - e. The facility shall maintain evidence of compliance with local and/or state health codes or ordinances regarding employee and consumer health status.
 - f. The facility shall screen all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings. All persons who provide services under an outside resource contract shall, upon request of the facility, provide evidence of compliance with this requirement.
 - g. All consumers shall be screened upon admission and after exposure to tuberculosis and provided follow-up as needed. DSHS will provide TB screening questionnaire for admission screening upon request.
 - h. Personnel who handle, store, process and transport linens shall do so in a manner that prevents the spread of infection.
 - i. Universal precautions shall be used in the care of all consumers.
 - j. First Aid Kits shall be sufficient for the number of consumers served at the site.
 - k. Gloves shall be immediately accessible to all staff.
 - l. One-way, CPR masks shall be immediately available to all staff.
 - m. Spill Kits shall be immediately accessible to all staff.
 - n. Running water or dry-wash disinfectant shall be available to staff where sinks are not easily available.
 - o. Sharps containers shall be puncture resistant, leak proof and labeled.
 - p. Sharps containers shall not be overfilled.
 - q. Needles in the sharps containers shall not be capped or bent.
 - r. Staff shall be able to accurately describe the policy for handling a full sharps container.
 - s. Particulate masks (surgical masks) shall be available to staff and individuals at high risk for exposure to TB.
 - t. Staff shall be able to describe the actions to take if exposed to blood or body fluids.
 - u. Staff shall be able to describe how to clean a blood or body-fluid spill.
 - v. Staff shall be able to direct surveyor to all protective equipment.
 - w. Poison Control phone numbers shall be posted throughout the Center.
 - x. Information regarding Emergency Medical Treatment for Poisoning shall be available to staff.
 - y. All medical materials shall be properly stored on shelves or in cabinets that shall be correctly labeled.
 - z. Disinfectants and externals shall be separated from internals and injectables.
 - aa. Medications that require special climatic conditions (e.g. refrigeration, darkness, tightly sealed, etc.) shall be stored properly.
 - ab. There shall be a thermometer in the refrigerator.
 - ac. Recorded refrigerator temperatures shall be maintained between 36 and 40 degrees Fahrenheit.
 - ad. Animals housed at the facility or visiting the facility shall be properly vaccinated and supervised.
- 8. Medication Management**
- a. All facilities that provide or store consumer medication during the length of stay shall implement written procedures for medication storage, administration, documentation, inventory, and disposal.
 - b. The facility shall maintain a record indicating that staff regularly checks the temperature in the refrigerator.
 - c. Refrigerators used to store medications shall be kept neat, clean and free of non-pharmacy / non-medical items. (Lab specimens shall be stored separately.)
 - d. The facility shall ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.
 - e. Individuals shall not be allowed to retain their own medications while in the facility.
 - f. Medications that are kept on-site shall be kept locked at all times.
 - g. Controlled substances shall be approved by a physician employed by or contracting with the facility or Community MHMR Center that operates the facility.
 - h. Controlled substances shall be stored under double locks.
 - i. Staff shall be able to provide a copy of the most recent stock inspection.
 - j. The facility management shall ensure that only licensed medical staff members have access to medications administered to individuals.
 - k. The facility management shall maintain a current list in the medications room of all practitioners who are allowed to prescribe medications that are administered from the medications room.
 - l. The facility management shall maintain a current list in the medication room of all staff allowed to administer medications to consumers.
 - m. The facility management shall ensure that staff does not ever transfer medications from one container to another. Consumers may independently transfer their own medications from a bottle to a daily medication reminder.
 - n. Medication labels shall not be handwritten or changed.
 - o. There shall be a medication guide, (e.g. Physician's Desk Reference (PDR) or similar publication) that is available to staff.
 - p. The PDR shall be current (i.e., an edition published within the previous 2 years).
 - q. The facility shall maintain an Emergency Medication Kit.
 - r. The medications in the emergency medication kit shall be monitored with a perpetual inventory and make use of breakaway seals.
 - s. The medication kit shall contain medications and other equipment as specified by the facility medical director. This generally includes but is not limited to short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications
 - t. There shall be evidence in the clinical records that consumers are educated about their medications whenever medications are prescribed or changed.
- 9. Food Preparation and Food Service**
- a. If the facility prepares meals in a centralized kitchen on site, it shall pass an annual kitchen health inspection as required by law. The facility shall immediately address any deficiencies found during any health inspection. The facility shall post the current food service permit from local health department.
 - b. If providing nutrition services, the kitchen or dietary area shall meet the general food service needs of the consumers. It shall include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal. Exception: Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.

- c. All facilities shall provide a means for washing and sanitizing dishes and cooking utensils must be provided. The kitchen shall contain a multi-compartment pot sink large enough to immerse pots and pans cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes. Separation of soiled and clean dish areas shall be maintained, including air flow.
- d. In facilities that prepare meals for consumers, at least three meals or their equivalent shall be served daily, at regular times, with no more than a 16-hour span between a substantial evening meal and breakfast the following morning.
- e. In all facilities, when therapeutic diets as are ordered they shall be provided by the facility.
- f. In facilities that prepare food for the consumers, the menus shall be prepared to provide a balanced and nutritious diet, such as recommended by the National Food and Nutrition Board, and will accommodate consumer kosher dietary needs or other related dietary practice.
- g. In facilities where consumers prepare their own food:
 - 1) The facility shall ensure that a variety of foods are available for each meal to allow consumers to have a choice of foods for to prepare for each meal;
 - 2) The facility shall ensure that the foods available are nutritious and well balanced such as recommended by the National Food and Nutrition Board and shall accommodate consumer kosher dietary needs or other related dietary practice;
 - 3) Food for at least 3 meals shall be provided daily for consumers to prepare;
 - 4) If consumers require special dietary items, the facility shall ensure that such items are provided to the consumer; and
 - 5) Regular food preparation and mealtimes shall be established by the facility.
- h. In all facilities, food and beverage shall be available to accommodate consumers who enter the facility after established meal times.
- i. In all facilities, supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period shall be maintained on premises. Food subject to spoilage shall be dated.
- j. When meals are provided by a food service, a written contract shall require the food service to: comply with the rules referenced in this Information Item V, and pass an annual kitchen health inspection as required by law. The facility shall ensure the meals are transported to the facility in temperature controlled containers to ensure the food remains at the temperature at which it was prepared. The facility shall ensure that at least one facility staff, at minimum, maintains a current food handler's permit.

10. Staffing

- a. A psychiatrist shall serve as the medical director for all crisis services and must approve all written procedures and protocols. Duties and responsibilities for all staff involved in the assessment or treatment of individuals shall be defined in writing by the medical director and be appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- b. The competence of all staff shall be continuously evaluated, monitored during the actual delivery of services and continually enhanced to address the unique needs of consumers in different settings and situations.
- c. An on-call roster of clinical (QMHP-CS and above) and nursing (RN and LVN) staff shall be maintained and a process must be in place for assessing and anticipating staffing needs to ensure clinical or nursing staff members are on-site at all times.
- d. Trained and competent professional staff (i.e. QMHPs) shall provide staff coverage during the first and second shifts.
- e. Trained and competent paraprofessional staff (i.e. non-licensed staff with less than a bachelors degree in a human services field) may used on the third (i.e., overnight) shift.
- f. Staff on duty shall remain awake and alert at all times.
- g. An LPHA shall be immediately available during the day and shall be responsible for ensuring the individual is provided active treatment defined in a crisis plan.
- h. There shall be a sufficient number of trained staff available to ensure that when individuals show signs of agitation there is immediate verbal intervention.
- i. No fewer than two staff members, trained in verbal and physical management of assaultive/aggressive behavior, shall be on site at all times to ensure a safe environment. When indicated by acuity and/or increased census, the number of staff trained in the verbal and physical management of assaultive/aggressive behavior shall be increased to a level that is sufficient to ensure the safety of all consumers and staff in the facility.
- j. When one-on-one supervision of one or more individuals is indicated, the facility shall ensure that there is sufficient staff on site to provide such supervision.
- k. At least one LPHA shall be available to conduct patient interviews and initiate a full assessment within eight hours of presentation to the unit or sooner when indicated.
- l. Active psychosocial programming shall be provided for at least 4 hours per day.
- m. Post admission, a physician (preferably a psychiatrist) or a psychiatric APN or PA shall see every individual at least once per week, or more frequently as clinically indicated, and be on call 24 hours a day to evaluate individuals as needed and to provide supervision and consultation.
- n. An RN shall be on call for emergencies, supervision and consultation 24 hours a day.
- o. A physician (preferably a psychiatrist), a psychiatric APN, a PA or an RN shall be on site or readily accessible to provide services either in person (or via telemedicine when appropriate).
- p. If a physician is not already on site, the physician (preferably a psychiatrist) or a psychiatric APN or PA shall be available to provide face-to-face services or via telemedicine when appropriate within one hour.
- q. If a RN is not on site, the RN shall be available to provide face-to-face services as soon as practically possible
- r. Facility staff shall take whatever measures are necessary to ensure the safety and well being during the time the physician or RN is in route to provide needed services.
- s. Staff shall not provide or facilitate consumer access to tobacco products.

11. Assessment

- a. Full Assessment
 - 1) Prior to admission to the crisis residential unit, individuals shall receive a full psychiatric assessment by a physician (preferably a psychiatrist) or a psychiatric APN or PA within 24 hours of the individual's presentation to the service if not referred directly from an active inpatient unit or psychiatric emergency service.
 - 2) A written process shall be implemented that ensures that those who require a full psychiatric assessment more quickly can be seen and assessed within 8 hours of initial presentation.
 - 3) Individuals not currently in services, or for whom the health status is unknown, shall receive a comprehensive nursing assessment by an RN within 1 hour of presentation.
- b. Assessment Process
 - 1) The assessment process includes patient interviews by LPHAs or PAs;
 - 2) When indicated and as appropriate, telemedicine may be used to conduct assessments.

- 3) The assessment process shall include a review of available records of past treatment;
- 4) The assessment process shall gather and incorporate:
 - a) Proactive history from family and collateral sources and in keeping with laws on confidentiality;
 - b) The assessment shall include contact with the current behavioral health providers whenever possible and in keeping with laws on confidentiality;
 - c) A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
 - d) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 - e) An assessment of the individual's ability and willingness to cooperate with treatment;
 - f) A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescribing practitioner;
 - g) A general medical history that addresses conditions that may affect the patient's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma);
 - h) A detailed assessment of substance use or abuse conducted by an individual trained in assessing substance related disorders;
 - i) An assessment for trauma, abuse or neglect by trained clinical staff, preferably an LPHA, with training in this assessment; and
 - j) A physical health assessment as outlined below.
- 5) Physical Health Assessment
 - a) Individuals shall receive a physical health assessment by a physician (preferably a psychiatrist) or a psychiatric APN or PA, or an RN, within two hours of entering a crisis residential unit unless:
 - i. Such an assessment was already conducted within the last week; and
 - ii. There are no recent changes or other indications that another assessment may be warranted.
 - b) This evaluation shall include assessment of medical and psychiatric stability, capability to self-administer medication, vital signs, pain, and dangerousness to self or others.
 - c) The initial evaluation for physical health shall be performed as ordered, by a physician (preferably a psychiatrist) or a psychiatric APN or PA and generally includes, but is not necessarily limited to:
 - i. Vital signs;
 - ii. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
 - iii. A screening neurological examination that is adequate to rule out significant acute pathology;
 - iv. A medical history and review of symptoms;
 - v. A pregnancy test (for females of child bearing age);
 - vi. A toxicology evaluation;
 - vii. Blood levels of psychiatric medications that have established therapeutic or toxic ranges; and
 - viii. Other tests and examinations including rapid toxicology testing as appropriate and indicated.
 - d) Access to phlebotomy and laboratory studies shall be provided.
 - e) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment shall be provided.
 - f) Screening for intoxication and, when indicated, screening for symptoms and complications of substance withdrawal shall be provided.

12. Interventions

- a. Upon admission but no later than 24 hours, every individual shall receive an orientation that explains facility rules and expectations, explains patients' rights and the grievance policy, and describes the schedule of activities.
- b. A written protocol shall be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the service and is approved by the clinical director. The written protocol shall be reviewed and updated as needed.
- c. An individual crisis treatment plan shall be developed for each individual that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. This information shall be shared with the individual and the individual's family, as appropriate. The plan shall be based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, individual preferences.
- d. An array of treatment interventions may exist in the crisis residential setting in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. A minimum of four hours per day of such programming shall be available and shall be provided. Services should be goal-oriented and focus on reality orientation, symptom reduction and management, appropriate social behavior, improving peer interactions, improving stress tolerance, and the development of coping skills; and may consist of the following component services: psychiatric nursing services, pharmacological instruction, symptom management training, and functional skills training. The programming requirements may be fulfilled through the provision of individual crisis intervention services or by providing group services. Group services may be delivered by service package assignment or through the provision of Day Programs for Acute Needs as specified in 25 TAC §419 L. Individuals who have significant substance abuse co-morbidity must receive counseling designed to motivate the patient to continue with substance abuse treatment following discharge from the program.
- e. Individuals shall not be denied access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.
- f. The program shall provide a stable therapeutic environment that includes consistently assigned personnel and consistently scheduled activities.
- g. Individuals should practice self-administration of medication under supervision. When needed, same-day access to medications shall be available and staff members shall provide medication education.

13. Coordination and Continuity of Care

- a. Coordination of emergency services shall be provided for every individual. Coordination of emergency services includes but is not limited to identifying and linking the individual with all available services necessary to stabilize the crisis, ensuring transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service.
- b. A written policy shall be in place that defines the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the individual's assessment in the service.
- c. A written procedure shall be developed and implemented to ensure continuity of care and successful linkage with the referral facility or provider.
- d. A discharge plan shall be developed for every individual, and shall include:
 - 1) Appropriate education relevant to the individual's condition;
 - 2) Information about the most effective treatment for the individual's behavioral health disorder;

- 3) Identification of potential obstacles to a successful return to the community and means to address these obstacles; and
- 4) Information about follow-up care, and appropriate linkages to post discharge providers.

VI. Crisis Respite Services

A. Definition

In contrast with crisis residential services, crisis respite services provide short-term, community-based residential, crisis treatment to persons who have low risk of harm to self or others and may have some functional impairment who require direct supervision and care but do not require hospitalization. These services can occur in houses, apartments, or other community living situations and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons for whom they care to avoid a mental health crisis. Utilization of these services is managed by the LMHA based on medical necessity. Crisis respite services may occur over a relatively brief period of time, such as a 2-hour service to allow a caretaker to complete necessary tasks or on a full day basis.

B. Goals

- Avoid an impending crisis due to housing challenges or other identified stressors in the family.
- Provide short-term assistance to caregivers of the consumer to minimize the need for a more restrictive service setting.
- Provide the consumer with appropriate supervision and assistance in a non-stressful environment
- Prevent unnecessary hospitalization and assist the individual in maintaining residence in the community

C. Description

Crisis respite treatment involves hourly or 24-hour care that is usually short-term and offered to individuals who are at risk of psychiatric crises due to a housing challenge and/or severe stressors in the family, but are at low risk of harm to self or others. Individuals must be able to cooperate with staff support, but functioning is only mildly impaired. If substance use is suspected that causes more than mild impairment this would not be an appropriate placement. There shall be defined processes in place to address substance use issues. Mild medical co-morbidity (as specified and approved by the facility medical director) is allowed while individual is taking his/her medications. Crisis respite units shall create a normalized environment (e.g., apartments, group and foster homes, and the individual's own home). This normalized environment provides a venue for biological, psychological, and social interventions targeted at the current crisis while fostering community reintegration. During facility-based respite, individual and group skills training are provided and are based on the needs of the individual and the goals of their individual crisis plans. Limited supervision shall be provided by trained and competent paraprofessionals. Individuals shall be able to perform their own activities of daily living. With staff supervision, individuals shall be able to self administer medication. Individuals should have enough medications upon arrival to ensure psychiatric and medical stabilization for the expected length of stay. There are procedures in place to obtain medications for individuals when needed. The primary objective of crisis respite services is stabilization and resolution of a crisis situation for the individual and/or the individual's caregiver(s). Crisis respite is both facility-based and in-home, and may be available for children, adolescents, and adults. The availability of facility-based respite units is dependent on LMHA funding for this type of respite.

D. Standards

1. Availability

- a. When offered, this service shall be available 24 hours a day, seven days a week and respite services shall be made available to individuals throughout the local service area.
- b. Admission to crisis respite shall be determined by the LMHA and shall be based on a medical necessity determination by an LPHA

2. Physical Plant

- a. For facility-based crisis respite, if the LMHA holds an Assisted Living Type A license, the facility will be accepted as "deemed status" by DSHS, and any Quality Management and Compliance reviews will entail only programmatic elements.
- b. Shall provide a clean and safe environment.
- c. Shall create a normalized environment.
- d. Crisis respite services units are not designed to prevent elopement and shall not use locks, mechanical restraints or other mechanical mechanisms to prevent elopement from the facility.
- e. All medications shall be securely stored.
- f. Contracted residential treatment centers or foster care homes that serve children and are used for crisis respite are subject to licensing regulations of the Department of Family and Protective Services (DFPS).

3. General Facility Environment

- a. A Crisis Respite Facility shall have 100% of its beds in bedrooms of four beds or less.
- b. When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall meet the Standards as described in Information Item V. Section D. Crisis Residential Services Item 3, General Facility Environment.

4. Accessibility (ADA Compliance)

Crisis respite facilities shall comply with ADAAG / TAS, and all applicable sections of the Texas Administrative Code.

5. Postings

- a. There shall be a list in or immediately outside of the medication room stating the names of all staff that have access to the medication room.
- b. Emergency telephone numbers, including at least fire, police, ambulance, EMS, and poison control center, shall be posted conspicuously at or near the telephone.
- c. If smoking areas are permitted, they shall be clearly marked as designated smoking areas.
- d. The facility shall prohibit firearms and other weapons, alcohol, illegal drugs, illegal activities, and violence on the program site.
- e. The following shall be prominently displayed in areas frequented by the consumers: contact information for the Rights Protection Officer, contact information with instructions on how to make an abuse/neglect report, toll-free number for reporting abuse and neglect, a notice stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
- f. If the facility prepares food, the facility shall post the current food service permit from the local health department.
- g. Postings shall be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.

6. Safety

When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall meet the Standards as described in Information Item V. Section D. Crisis Residential Services Item 6, Safety.

7. Infection Control

When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall meet the Standards as described in Information Item V. Section D. Crisis Residential Services Item 7, Infection Control.

8. Medication Management

When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall follow the Standards as described in Information Item V. Section D. Crisis Residential Services Item 8, Medication Management, except

for D.8.q. An Emergency Medication Kit should be maintained if the facility contains the staff qualified to handle such medications.

9. Food Preparation and Food Service

When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall meet the Standards as described in Information Item V. Section D. Crisis Residential Services Item 9, Food Preparation and Food Service.

10. Staffing for Facility-based Crisis Respite

- a. A psychiatrist shall serve as the medical director for all crisis services and shall approve all written procedures and protocols. Duties and responsibilities for all staff involved in the assessment or treatment of individuals shall be defined in writing by the medical director and be appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- b. The competence of all crisis respite staff members shall be continuously evaluated, monitored and expanded.
- c. There shall be a process for assessing and anticipating staffing needs.
- d. Staff members on duty shall remain awake and alert at all times.
- e. There shall be a defined process for on-site staff to obtain supervision, consultation, and evaluation when needed for medical emergencies 24 hours a day from a physician (preferably a psychiatrist), a psychiatric APN, a PA or an RN. For clinical emergencies an RN or LPHA shall be accessible.
- f. Trained and competent paraprofessionals shall be on site 24 hours a day, with numbers, qualifications, and training sufficient to ensure patient and staff safety and the provision of needed services.
- g. Staff members shall be trained in CPR, management of seizures, choking, and first aid as well as crisis respite protocols and procedures, and supervision of self-administration of medications.
- h. Staff members providing in-home crisis respite services to children or adolescents shall be trained paraprofessionals competent to provide crisis services to children and adolescents.
- i. Staff shall not provide or facilitate consumer access to tobacco products

11. Assessment

- a. Prior to admission to crisis respite services individuals shall receive a full crisis assessment by a physician (preferably a psychiatrist) or a psychiatric APN or PA, LPHA, RN or QMHP-CS.
- b. Immediate access to urgent and emergent non-psychiatric medical assessment and treatment shall be provided.

12. Interventions for Facility-based Crisis Respite

- a. Upon admission, every individual shall receive an orientation that explains rules and expectations, explains patients' rights and the grievance policy, and describes the schedule of any activities.
- b. Immediate care to stabilize a behavioral health emergency (e.g., to prevent harm to the individual or to others) shall be accessible at all times.
- c. A written protocol shall be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the service and is approved by the medical director. The protocol shall be reviewed and updated as needed.
- d. An individual crisis treatment plan shall be followed for each individual that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. This information shall be shared with the individual and the individual's family, as appropriate. The plan shall be developed by qualified crisis staff and shall be based on the provisional psychiatric diagnosis and must incorporate, to the maximum extent possible, individual preferences.
- e. An array of treatment interventions shall be provided in the crisis respite setting in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Services should be goal-oriented and based on the individual's needs and individual crisis plan. Services should focus on reality orientation, symptom reduction and management, appropriate social behavior, improving peer interactions, improving stress tolerance, and the development of coping skills; and may consist of the following component services: psychiatric nursing services, pharmacological instruction, symptom management training, and functional skills training. The programming requirements may be fulfilled through the provision of individual crisis intervention services or by providing group services. Group services may be delivered by service package assignment or through the provision of Day Programs for Acute Needs as specified in 25 TAC Chapter 419, Subchapter L. Individuals who have significant substance abuse co-morbidity shall receive counseling designed to motivate the patient to continue with substance abuse treatment following discharge from the program.
- f. Each consumer's response to treatment shall be reassessed daily by staff. This response shall be reflected in an updated crisis treatment plan.
- g. Individuals shall not be denied access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.
- h. Facility-based crisis respite units shall maintain a stable therapeutic environment that includes assigned personnel and scheduled activities.

13. Coordination and Continuity of Care

- a. Coordination of emergency services shall be provided for every individual. Coordination of emergency services includes but is not limited to identifying and linking the individual with all available services necessary to stabilize the crisis, ensuring transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service.
- b. A written policy shall be developed and implemented that defines the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the individual's assessment in the service.
- c. A written procedure shall be developed and implemented to ensure continuity of care and successful linkage with the referral facility or provider.
- d. A discharge plan shall be developed for every individual, and shall include:
 - 1) Appropriate education relevant to the individual's condition;
 - 2) Information about the most effective treatment for the individual's behavioral health disorder;
 - 3) Identification of potential obstacles to a successful return to the living situation of the individual's choice and means to address these obstacles; and
 - 4) Information about follow-up care, and appropriate linkages to post discharge providers.